CHILDREN AND ADOLESCENTS

Our most precious resource

Oft-repeated statements about our children, though they have become clichés, are nevertheless absolutely true. Our children *are* our future. They are our most precious resource. Their welfare is one of the few things that everyone in the world would agree is worth striving for. Politics, religions and customs still, unfortunately and sometimes tragically, divide us but the welfare of our children is one of the concerns that unites us – without any question whatsoever. The theme of this issue of *Diabetes Voice* is diabetes in children and adolescents. Unless we focus on this theme - and act - the welfare of our children and adolescents who have diabetes – either type 1 or type 2 – will suffer. If we let that happen, how will we explain our failing to them now and when they are adults?

I was pleased to see, in a recent issue of *Diabetologia*, the paper by Persson and colleagues dealing with the impact of childhood-onset type 1 diabetes on schooling – educational achievement at the end of compulsory education and the end of upper secondary education – and on employment status later in life. As someone who has, from time to time, contributed to the literature on the individual and societal costs of diabetes, I have often thought that the 'cost' (in the widest sense) of diabetes on the education of children was virtually unrecorded. In contrast, the monetary cost of diabetes to the individual and family and the cost to society of lost production of adults with diabetes have both been intensely studied. That study, from Sweden, found that the presence of diabetes had an adverse effect on children's final grades and that those who had diabetes as children were less likely to be 'gainfully employed' at the age of 29. As was highlighted in a commentary on the paper in the same issue of the journal, the effects found were small in magnitude but their magnitude is likely to be very dependent on the nature of the support given to children in any particular school system. Thus, though small in Sweden, the effects may be much larger elsewhere. My hunch would be that they are.

The first of the selection of articles in the 'Currently in *Diabetes Research and Clinical Practice*' section of *News in Brief* in this issue is specifically about children. It's a study which asks the question: do attitudes to blood glucose monitoring of children with type 1 diabetes have an impact on family harmony? The short answer is: yes, they do. Further on in this issue is an article, originally published in the same journal, about a different aspect of the same topic: to what extent are the recommendations of children's care providers (i.e. diabetologists and diabetes specialist nurses in the main) about the frequency of self monitoring of blood glucose actually carried out in practice?

Authoritative guidelines on the monitoring of blood glucose in type 1 diabetes are demanding – four or more tests per day in most instances. This has a cost – financial (either to the health system or to the family, depending on circumstances), practical (in terms of the time and facilities needed to carry them out) and emotional (in terms, for example, of the constant reinforcing of being 'different' from everyone else who don't need to do this). Both studies have approached, from different perspectives, the multi-faceted question of the feasibility of adhering to these guidelines. Both studies are from the USA. The question of feasibility must be much more marked in low-resource environments.

Another recent *Diabetologia* article (Lind, et al, available on-line) is the demonstration that, at least in Canada and the UK, prospects seem to be improving in terms of mortality outcomes for people with diabetes compared with people without diabetes of the same age. Overall, the excess mortality of people with diabetes has fallen from about twice that of people without diabetes in 1996 to around one-and-a-half times in 2009. This is still not satisfactory but it is a trend in the right direction. The authors speculate that this fall is 'in part due to earlier detection and higher prevalence of early diabetes, as well as to improvements in diabetes care'. It's too early to unfurl the flags and sound the trumpets yet since we need data like these from other countries but it is encouraging to feel that the prospects for our children may be better in the future than they were in the past.

On the last page of this issue is a new feature – *Voice Box* – the *Diabetes Voice* Inbox. Your comments on our publication are invited – via diabetesvoice@idf.org. Please keep them coming in. We are aiming for this magazine to be *interactive* as well as *active*.

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